

MDR Tracking Number: M5-04-3180-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on May 24, 2004. Per Rule 133.308(e)(1) date of service 05/22/03 is not within the 365-day timeframe and outside the jurisdiction of MDR and will not be reviewed.

The IRO reviewed office visits, therapeutic exercises, myofascial release, joint mobilization, chiropractic manipulations, neuromuscular re-education and physical performance evaluation from 05/29/03 through 10/16/03 that were denied based upon "U".

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

CPT Code **97750** for date of service 09/25/03; CPT Code **97110** for dates of service 05/29/03, 06/02/03 through 06/04/03, and 07/14/03 through 07/30/03; CPT Code **97250** for date of service 05/29/03; CPT Code **97112** for dates of service 05/29/03 through 06/04/03 and 07/14/03 through 07/30/03; CPT Code **97265** for dates of service 05/29/03, 06/03/03, and 06/4/03; CPT Code **97110, 3 units only**, for dates of service 07/14/03 through 08/26/03; CPT Code **97112, 1 unit only**, for dates of service 07/14/03 through 08/26/03; and CPT Code **99213** for dates of service 06/10/03, 06/16/03, 07/14/03, 08/05/03, 09/11/03, 09/24/03 and 10/16/03 **were** found to be medically necessary. All remaining services **were not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for office visits, therapeutic exercises, myofascial release, joint mobilization, chiropractic manipulations, neuromuscular re-education and physical performance evaluation.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

On August 9, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

- CPT Code 99080-73 (3) for dates of service 06/16/03 through 08/13/03 denied as "V". Per Rule 129.5 The Work Status Report (TWCC-73) is a required form and MDR has jurisdiction over these matters. Per Rule 133.106(f)(1) reimbursement in the amount of \$45.00 (\$15.00 x 3) is recommended.

This Decision is hereby issued this 4th day of November, 2004

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees outlined above as follows:

- in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;
- in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c);
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

This Order is applicable to dates of service 05/29/03 through 10/16/03 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 4th day of November, 2004

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review

RL/MF/mf

Enclosure: IRO decision

Amended Report

10/26/2004

David Martinez
TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient:
TWCC #:
MDR Tracking #: M5-04-3180-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Specialty IRO for independent review in accordance with TWCC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Chiropractor. The reviewer is on the TWCC ADL. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ sustained a work related injury while working for the City of ___ on ___. He initially treated with Accident and Injury Chiropractic on 11/26/02. He complained of right shoulder, right knee and low back pain. MRI of the lumbar spine demonstrated L5/S1 spondylolisthesis, MRI of the right shoulder demonstrated an acute comminuted fracture of the lateral surface of the humeral head at the anatomic and surgical neck of the humerus. A recommended CT scan was apparently not performed. The patient changed doctors to Dr. McKinney at Westlake Medical Center. He was placed in physical therapy and work conditioning when he again changed doctors to Angela Upchurch DC in February of 2003. The patient was placed in passive therapies after doing well in active therapy. Dr. Upchurch ordered EMG/NCV and SSEP which were read as normal. A peer review by Kellie Lancaster, DC indicates the patient was not improving. Passive therapies were stated to not be indicated and a RME and FCE were indicated. On 4/4/03, she saw Benjamin Cunningham, MD who recommended a consult with Richard

Bush, MD, orthopedic tumor specialist. ESI and myofascial injections were performed. A bone biopsy was recommended on 5/27/03. The test revealed a post traumatic lesion. Dr. Cunningham recommended a discogram at L4/5 and L5/S1 with L3/4 as a control. FCE's were performed on 5/22/03, 7/31/03 and 9/25/03. Marginal improvement was noted to 7/31/03. Therapies resume on 7/14/03 for post-surgical rehabilitation on the upper extremity. Discogram of 9/17/03 indicates a posterior fissure with extravasation posteriorly, grade V fissure at L4/5 and grade IV at L5/S1. As of 7/26/03, George Medley, MD performed a peer review indicating that the bone cyst was including in the extent of injury but that it was not related to the injury.

DISPUTED SERVICES

Disputed services include office visit, therapeutic exercises, myofascial release, joint mobilization, chiropractic manipulations, neuromuscular re-education and physical performance evaluation from 5/29/03 through 10/16/03.

DECISION

The reviewer notes the following services were found to be medically necessary: 97750 (9/25/03; 97110 5/29/03, 6/2/03, 6/03/03, 6/4/03, 7/14/03, 7/16/03, 7/17/03, 7/21/03, 7/22/03, 7/29/03, 7/30/03; 97250 5/29/03; 97112 5/29/03, 6/2/03, 6/03/03, 6/4/03, 7/14/03, 7/16/03, 7/17/03, 7/21/03, 7/22/03, 7/29/03, 7/30/03 ; 97265 5/29/03, 6/03/03, 6/4/03; The reviewer allows as medically necessary 3 units of 97110 and 1 unit of 97112 from 7/14/03, 7/16/03, 7/17/03, 7/22/03, 7/29/03, 7/30/03, 8/1/03, 8/5/03, 8/6/03, 8/7/03, 8/13/03, 8/14/03, 8/15/03, 8/19/03, 8/21/03 and 8/26/03. 99213 6/10/03, 6/16/03, 7/14/03, 8/5/03, 9/11/03, 9/24/03, 10/16/03.

The reviewer notes all remaining services to be not medically necessary.

BASIS FOR THE DECISION

The reviewer notes that after thorough consideration of all records provided, that the PPE on 5/22/03 is indicated. Unfortunately, there is indication that the lumbar spine ROM was worsening rather than improving but functional lifting components were improving. By 7/31/03 PPE there is not a significant increase in ROM and it worsens in some cases. The lifting portion of this PPE indicates leg lift improvement. But a note on 8/5/03 states that surgery is recommended and the patient's subjective complains are worsening in the lumbar spine. The PPE of 9/25/03 is also necessary as this was the last of the active therapies for the shoulder.

The reviewer recommends the active therapies from 5/29/03 through 7/31/03 as being reasonable and necessary due to improvement of the PPE's. This is also based upon TX Labor Code 408.021 and the Mercy Guidelines. After 7/31/03, therapy for the lumbar spine cannot be recommended. Dr. Cunningham recommends surgery on 8/5/03. The treatment for the lumbar spine had clearly plateaued by the PPE on 7/31/03; therefore, any therapy after this date is not necessary. The PPE on 9/25/03 demonstrates a marked decrease in lumbar ROM and increased

subjective complaints. Mercy conference and Rand Consensus Panel findings do not support ongoing care with demonstrated improvement between evaluations that is significant.

Therapies for the right upper extremity for post-surgical therapy would be appropriate beginning on 7/14/03 through 8/26/03. This is supported by the PPE noting increased ROM and strength. TLC 408.021 and post surgical rehabilitation protocols note the medical necessity of approximately 8 weeks of post-surgical rehabilitation for the shoulder. The reviewer notes that the entirety of services performed within this time frame is not supported (only that involved with the upper extremity). The reviewer recommends three (3) units of therapeutic activities be approved as per the submitted documentation. Furthermore, one (1) unit of neuromuscular re-education is supported on each date of service of the above-mentioned time frame. The reviewer notes that the date of service 7/21/03 is not supported as the records provided name the patient, Sherry Smith, and not Aaron Sims.

The reviewer would not consider office visits or spinal manipulations appropriate during the dates in question with the exception of 6/10/03, 6/16/03, 7/14/03 and 8/5/03 where the reviewer notes the 99213 code in question to be appropriately utilized. The reviewer does not support the utilization of 98940 at any point as chiropractic manipulation was previously utilized and did not improve the patient's condition. In fact the records suggest that the patient's condition worsened in the lumbar spine with manipulation which is likely if extension exercises are to be avoided such as Dr. Cunningham's recommendations. Furthermore, a 99213 and 98940 billed on the same date is considered unbundling if a modifier -25 is not included. The reviewer indicates as necessary office visits (99213) on 9/11/03 and 9/24/03 and 10/16/03 due to a change in treatment plan due to new information being introduced. The therapy on 9/11/03 is not supported due to a two week lapse in care and a lack of justification for these therapies in the medical records.

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that there is no known conflict between the reviewer, Specialty IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,

Wendy Perelli, CEO
CC: Specialty IRO Medical Director